



RELEASE OF INFORMATION MORTALITY REVIEW

State Form 53267 (R / 4-08) / QA 1000

Family and Social Services Administration
Division of Aging
Mortality Review Committee

PURPOSE: This form is used to confirm the direction of the personal representative to disclose the deceased individual's protected health information for mortality review purposes only.

SECTION A: THE INDIVIDUAL'S PERSONAL REPRESENTATIVE CONFIRMING THE AUTHORIZATION

I authorize the use and/or disclosure of the protected health information as described in Section B below. I understand this authorization is voluntary and made to confirm direction.

I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Name of deceased individual	Social Security number
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Address (number and street, city, state, and ZIP code)

Name of personal representative for deceased individual	Telephone number ()
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Address (number and street, city, state, and ZIP code)

SECTION B: THE USE AND/OR DISCLOSURE BEING AUTHORIZED

PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED: Specifically and meaningfully describe the protected health information you are authorizing to be used and/or disclosed.

ENTITIES AUTHORIZED TO USE OR DISCLOSE: Name or specifically identify the persons or organizations (or the classes of persons and/or organizations), including Provider, who you are authorizing to make use of and/or to disclose the protected health information described above.

Mortality Review Committee of Indiana Division of Aging	

SECTION C: SIGNATURE AND REVOCATION

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the Provider. I understand that, by signing this form, I am confirming my authorization that the Provider may use and/or disclose to the persons and/or organizations named in this form the protected health information concerning _____ as described in Section A.
Deceased individual

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Signature of personal representative	Date (month, day, year)
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Name of personal representative	Relationship to deceased individual
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If preferred, information can be released directly to :
Mortality Review Committee, Division of Aging; Attn: Brenda Hogan; 402 West Washington Street; IGCS, Room W454, MS-21;
PO Box 7083; Indianapolis, IN 46207-7083; Telephone number (317) 232-7132; Fax number (317) 232-7867.

If multiple release forms are necessary, this form may be copied.